

		FOR OFF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040014</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manorcare at Skokie</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/99</u> to <u>05/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p>	
Address: <u>4660 Old Orchard Rd.</u> <u>Skokie</u> <u>60076</u> <div style="display: flex; justify-content: space-between;"> Number City Zip Code </div>		<p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>	
County: <u>Cook</u>		<div style="display: flex;"> <div style="border: 1px solid black; padding: 2px;"> Officer or Administrator of Provider </div> <div> (Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u> (Title) <u>Vice President - Reimbursement</u> </div> </div>	
Telephone Number: <u>(847) 676-4800</u> Fax # <u>(847) 676-4860</u>		<div style="display: flex;"> <div style="border: 1px solid black; padding: 2px;"> Paid Preparer </div> <div> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </div> </div>	
IDPA ID Number: <u>520886946020</u>		<div> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </div>	
Date of Initial License for Current Owners: <u>11/01/94</u>			
Type of Ownership:			
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>			
In the event there are further questions about this report, please contact: Name <u>Craig Dekany</u> Telephone Number: <u>(419) 252-5740</u>			

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Manorcare at Skokie# 0040014 Report Period Beginning: 06/01/99 Ending: 05/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>56</u>	Skilled (SNF)	<u>56</u>	<u>20,496</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>56</u>	TOTALS	<u>56</u>	<u>20,496</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1</u>	<u>50</u>	<u>3,673</u>	<u>3,724</u>	8
9	SNF/PED					9
10	ICF	<u>2,534</u>	<u>5,674</u>	<u>946</u>	<u>9,154</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,535</u>	<u>5,724</u>	<u>4,619</u>	<u>12,878</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 62.83%)D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 11/01/94J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/01/94 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 18 and days of care provided 2677Medicare Intermediary BCBS Maryland

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/00 Fiscal Year: 05/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/99 Ending: 05/31/00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	119,441	9,817	18,223	147,481	523	148,004	0	148,004		1
2	Food Purchase		59,824		59,824		59,824	(969)	58,855		2
3	Housekeeping	60,554	4,988	1,130	66,672		66,672	0	66,672		3
4	Laundry	47,800	2,297	409	50,506		50,506	(5,354)	45,152		4
5	Heat and Other Utilities			64,224	64,224	6,210	70,434	0	70,434		5
6	Maintenance	29,289	14,093	40,141	83,523		83,523	0	83,523		6
7	Other (specify):*			200	200		200	0	200		7
8	TOTAL General Services	257,084	91,019	124,327	472,430	6,733	479,163	(6,323)	472,840		8
	B. Health Care and Programs										
9	Medical Director			10,410	10,410		10,410	0	10,410		9
10	Nursing and Medical Records	692,547	88,237	36,995	817,779	10,483	828,262	0	828,262		10
10a	Therapy	198,200	1,562	24,981	224,743		224,743	0	224,743		10a
11	Activities	39,001	2,100	3,557	44,658		44,658	0	44,658		11
12	Social Services	33,592	39		33,631		33,631	0	33,631		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	963,340	91,938	75,943	1,131,221	10,483	1,141,704		1,141,704		16
	C. General Administration										
17	Administrative	54,953		134,823	189,776	(26,564)	163,212	0	163,212		17
18	Directors Fees							0			18
19	Professional Services			10,068	10,068	(7,707)	2,361	(2,361)			19
20	Dues, Fees, Subscriptions & Promotions			77,165	77,165		77,165	(18,191)	58,974		20
21	Clerical & General Office Expense	195,944	19,416	(180,252)	35,108	5,632	40,740	218,932	259,672		21
22	Employee Benefits & Payroll Taxes			260,847	260,847	700	261,547	0	261,547		22
23	Inservice Training & Education			3,391	3,391		3,391	0	3,391		23
24	Travel and Seminar			8,493	8,493		8,493	0	8,493		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			31,444	31,444		31,444	0	31,444		26
27	Other (specify):*							0			27
28	TOTAL General Administration	250,897	19,416	345,979	616,292	(27,939)	588,353	198,380	786,733		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,471,321	202,373	546,249	2,219,943	(10,723)	2,209,220	192,057	2,401,277		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			291,222	291,222	10,723	301,945	0	301,945		30
31	Amortization of Pre-Op. & Org.			1,000	1,000		1,000	0	1,000		31
32	Interest			392	392		392	(643)	(251)		32
33	Real Estate Taxes			138,198	138,198		138,198	0	138,198		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			17,074	17,074		17,074	0	17,074		35
36	Other (specify):*							0			36
37	TOTAL Ownership			447,886	447,886	10,723	458,609	(643)	457,966		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		119,691	22,067	141,758		141,758	0	141,758		39
40	Barber and Beauty Shops		6,456	650	7,106		7,106	0	7,106		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			46,010	46,010		46,010	0	46,010		42
43	Other (specify):*		41,516	0	41,516		41,516	0	41,516		43
44	TOTAL Special Cost Centers		167,663	68,727	236,390		236,390		236,390		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,471,321	370,036	1,062,862	2,904,219	0	2,904,219	191,414	3,095,633		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Manorcare at Skokie

0040014

Report Period Beginning: 06/01/99

Ending: 05/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(969)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,142)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(5,354)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(643)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,820)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(450)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,361)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	230,344	21		24
25	Fund Raising, Advertising and Promotional	(18,191)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 191,414		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 191,414		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Manorcare at Skokie

0040014 Report Period Beginning:

06/01/99

Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY	
													TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(969)	0	0	0	0	0	0	0	0	0	0	(969)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(5,354)	0	0	0	0	0	0	0	0	0	0	(5,354)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,323)	0	0	0	0	0	0	0	0	0	0	(6,323)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,361)	0	0	0	0	0	0	0	0	0	0	(2,361)	19
20	Fees, Subscriptions & Promotions	(18,191)	0	0	0	0	0	0	0	0	0	0	(18,191)	20
21	Clerical & General Office Expenses	218,932	0	0	0	0	0	0	0	0	0	0	218,932	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	198,380	0	0	0	0	0	0	0	0	0	0	198,380	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	192,057	0	0	0	0	0	0	0	0	0	0	192,057	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: Manorcare at Skokie

0040014

Report Period Beginning:

06/01/99

Ending:

05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(643)	0	0	0	0	0	0	0	0	0	0	(643)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(643)	0	0	0	0	0	0	0	0	0	0	(643)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	191,414	0	0	0	0	0	0	0	0	0	0	191,414	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number: **Monterey at Shasta** (Show Pgs 6A thru 6) STATE OF ILLINOIS Report Period Beginning: 06/01/09 Ending: 05/31/10

VI. RELATED PARTIES (Show Pgs 6A thru 6) (Show Pgs 6B thru 6)

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	City
MonterCare, Inc.	100	Health Care & Retirement Corporation	Yuba, CA		
		SEE ALSO CARE BENEFIT			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ Yes ☒ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for disclosing costs as specified for this form.

Schedule V Line	1	2	3	4	5	6	7	8
	Cost Center	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Costs of Related Organization	Adjustments for Related Organization	Cost Center
1	V	Supplies	128,875	HCW Manor Care, Inc.	100.00%	128,875		1
2	V	Page						2
3	V							3
4	V							4
5	V							5
6	V	Bed Therapy Management	15,521	Boardman Management Services	100.00%	15,521		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	V							14
15	V							15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
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232	V							232
233	V							233
234	V							234
235	V							235
236	V							236
237	V							237
238	V							238
239	V							239
240	V							240
241	V							24

Facility Name & ID Number Manorcare at Skokie# 0040014Report Period Beginning: 06/01/99Ending: 05/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

[Print Preview](#)

| the name(s)
PORTS.

Facility Name & ID Number Manorcare at Skokie# 0040014 Report Period Beginning: 06/01/99Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR ManorCare, Inc.Street Address 333 North SummitCity / State / Zip Code Toledo, OH 43604Phone Number (419) 252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1 Dietary	Accumulated Cost	#####	357 Nurs. Fac.	\$ 388,478	\$ 221,496	134,823	\$ 523	1
2	5 Utilities	Accumulated Cost	#####	357 Nurs. Fac.	4,614,666		134,823	6,210	2
3	10 Nursing	Accumulated Cost	#####	357 Nurs. Fac.	6,247,503	4,177,723	134,823	8,408	3
4	17 General & Administrative	Accumulated Cost	#####	357 Nurs. Fac.	80,443,795	26,746,978	134,823	108,259	4
5	22 Employee Benefits	Accumulated Cost	#####	357 Nurs. Fac.	520,233		134,823	700	5
6	30 Depreciation	Accumulated Cost	#####	357 Nurs. Fac.	7,968,019		134,823	10,723	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 100,182,694	\$ 31,146,197		\$ 134,823	25

Print Preview

Facility Name & ID Number Manorcare at Skokie# 0040014 Report Period Beginning: 06/01/99Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Manorcare at Skokie# 0040014 Report Period Beginning: 06/01/99Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Manorcare at Skokie# 0040014 Report Period Beginning: 06/01/99Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Manorcare at Skokie# 0040014 Report Period Beginning: 06/01/99Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	N/A						\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related											9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related											14							
15	TOTALS (line 9+line14)											15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number Manorcare at Skokie# 0040014 Report Period Beginning: 06/01/99 Ending: 05/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<u>138,198</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>138,198</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>138,198</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<u>138,198</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<u>106,993</u>	8		
	1996	<u>109,094</u>	9		
	1997	<u>109,878</u>	10		
	1998	<u>110,145</u>	11		
	1999	<u>110,271</u>	12		

	FOR OFF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
R/E Tax Payments	15	LESS REFUND FROM LINE 6 \$	15
<u>1999 \$73,819.19</u>			
<u>2000 \$64,379.21</u>	16	AMOUNT TO USE FOR RATE CALCULATIO \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number: Manorcare at Skokie
X. BUILDING AND GENERAL INFORMATION:

STATE OF ILLINOIS

0040014 Report Period Beginning:

06/01/99 Ending:

Page 11
05/31/00

A. Square Feet: 14,808 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [] NO
If so, please complete the following:

1. Total Amount Incurred: 122,719 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 1,000 4. Dates Incurred: 1995 & 1996

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1994	\$ 300,000	1
2					2
3	TOTALS			\$ 300,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Manorcare at Skokie

0040014

Report Period Beginning:

06/01/99

Ending:

05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61			1994	\$ 1,940,000	\$ 48,500		\$ 48,500	\$	\$ 266,750	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Leasehold Improvements (Current Year Depreciation)					81,714		81,714		308,360	9
10				1995	1,331,819						10
11	Doors/Windows			1996	7,023						11
12	Electrical			1996	4,374						12
13	Professional Services			1996	8,622						13
14	Medical Gas System			1996	3,449						14
15	Replace Water Pump Unit			1996	3,634						15
16	Doors/Hardware			1996	4,847						16
17	Carpeting			1996	2,342						17
18	Medical Gas System			1996	19,419						18
19	Professional Fees			1996	6,529						19
20	Wallcovering			1996	25,335						20
21	Plumbing			1996	60,000						21
22	Remodel OT			1996	1,464						22
23	Remodel Washrooms			1996	20,681						23
24	Electrical			1996	7,291						24
25	HVAC/Ductwork			1996	4,891						25
26	Wall Repairs			1996	1,692						26
27	Doors			1996	1,812						27
28	Landscaping			1997	1,762						28
29	Phone System			1997	2,458						29
30	Wallcoverings			1997	1,502						30
31	HVAC			1997	21,340						31
32	Carpeting			1997	5,314						32
33	Install CATV Jacks			1997	5,548						33
34	Remodel Offices			1997	22,516						34
35	HVAC			1997	8,508						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 130,214		\$ 130,214	\$	\$ 575,110	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe Manorcare at Skokie

0040014

Report Period Beginning:

06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Repair Walls			1997	1,328						9
10	Install New Siding			1997	20,000						10
11	Install Shower Tile			1997	15,817						11
12	Install Ball Valve			1997	1,955						12
13	Kitchen Plumbing			1997	7,446						13
14	Remodeling Tub/Shower			1997	9,300						14
15	Nurse Call Service			1997	1,795						15
16	Lighting			1997	13,266						16
17	Flooring			1997	6,671						17
18	New Siding/Soffit			1997	14,600						18
19	Office Remodeling			1998	6,000						19
20	Toilet Access			1998	1,612						20
21	Soors/Windows			1998	14,763						21
22	Electrical			1998	4,289						22
23	Carpeting			1998	3,457						23
24	Roofing			1998	1,915						24
25	HVAC			1998	11,786						25
26	Painting/Wallcoverings			1998	5,240						26
27	Painting/Wallcovering			1998	2,266						27
28	Developers			1998	5,555						28
29	HVAC			1998	797						29
30	Sign			1998	11,862						30
31	Comm. Edison			1998	2,842						31
32	Painting/Wallcovering			1999	62						32
33	Paving			1998	18,870						33
34	General construction			1999	6,241						34
35	Vinyl Wall Border			1999	191						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12B

Facility Name & ID Numbe Manorcare at Skokie

0040014

Report Period Beginning:

06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Suite Signs			1999	942						9
10	Wallcoverings			1999	3,101						10
11	Wall Borders			1999	1,339						11
12	Vinyl Wallcoverings			1999	512						12
13	Freight			1999	117						13
14	Relaminate Nurse Station			1999	7,015						14
15	Carpet			1999	14,458						15
16	Mag Door Holders			1999	756						16
17	Carpeting			1999	557						17
18	Handrail			2000	5,480						18
19	Border			2000	650						19
20	Molding & Painting			2000	3,958						20
21	Freight Wallcovering			2000	117						21
22	Heating			2000	7,015						22
23	Heritage Corridors			2000	7,618						23
24	Door Fram Protection			2000	741						24
25	Door Hardware			2000	49						25
26	Solarium			2000	3,260						26
27	VWC, Corner Guards, & Painting			2000	5,772						27
28	Carpet			2000	752						28
29	Freight Carpet			2000	68						29
30	Plumbing Public Restrooms			2000	989						30
31	Plumbing remaining balance			2000	989						31
32	Door Work/Heating			2000	832						32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Manorcare at Skokie# 0040014Report Period Beginning: 06/01/99 Ending: 05/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 1,245,077	\$ 161,008	\$ 161,008	\$		\$ 793,622	37
38	Current Year Purchases	16,116						38
39	Fully Depreciated Assets							39
40	H/O Allocation			10,723	10,723			40
41	TOTALS	\$ 1,261,193	\$ 161,008	\$ 171,731	\$ 10,723		\$ 793,622	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 291,222	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 301,945	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 10,723	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,368,732	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO16. Rental Amount for movable equipm: \$ 17,074Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Manorcare at Skokie

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0040014Report Period Beginning: 06/01/99 Ending: 05/31/00**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Manorcare at Skokie# 0040014

Report Period Beginning:

06/01/99

Ending:

05/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	10A	3,141	hrs	\$ 72,957	260	\$ 6,494	\$ 343	3,401	\$ 79,794	1	
2	Licensed Speech and Language Development Therapist	10A	716	hrs	13,831	282	7,039	49	998	20,919	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10A	4,574	hrs	111,412	458	11,448	1,170	5,032	124,030	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39		# of prescripts				119,691		119,691	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify): P/S Pharm, IV Ther	39					22,067			22,067	13	
14	TOTAL				\$ 198,200	1,000	\$ 47,048	\$ 121,253	9,431	\$ 366,501	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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STATE OF ILLINOIS

Page 17

Facility Name & ID Number Manorcare at Skokie

0040014

Report Period Beginning: 06/01/99

Ending:

05/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 22,057	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (141,483))	378,456		3
4	Supply Inventory (priced at)	11,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,795		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 415,308	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	356,977		13
14	Buildings, at Historical Cost	3,724,209		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,261,192		16
17	Accumulated Depreciation (book methods)	(1,368,732)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	167		22
23	Other(specify): CIP	(313)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,973,500	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,388,808	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 82,613	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,871		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,327		31
32	Accrued Real Estate Taxes(Sch.IX-B)	138,198		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	50,973		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 348,982	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 348,982	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,737,790)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (4,388,808)	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,244,550)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,244,550)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(522,578)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (522,578)	17
	B. Transfers (Itemize):		
18	Change In Interdivision	(1,970,662)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,970,662)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,737,790)	24 *

* This must agree with page 17, line 47.

Print Preview

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Manorcare at Skokie

0040014

Report Period Beginning: 06/01/99

Ending:

05/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,210,478	1
2	Discounts and Allowances for all Levels	(674,126)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,536,352	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	706,550	6
7	Oxygen	854	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 707,404	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	450	12
13	Barber and Beauty Care	8,805	13
14	Non-Patient Meals	969	14
15	Telephone, Television and Radio	4,142	15
16	Rental of Facility Space		16
17	Sale of Drugs	117,522	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,354	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 137,242	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	643	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 643	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,381,641	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 472,430	31
32	Health Care	1,131,221	32
33	General Administration	616,292	33
B. Capital Expense			
34	Ownership	447,886	34
C. Ancillary Expense			
35	Special Cost Centers	236,390	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,904,219	40
41	Income before Income Taxes (line 30 minus line 40)**	(522,578)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (522,578)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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